Dec 96
DoD 1400.25-M

Claim for Continuing Compensation on Account of Disability

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Statement of Injured Employee - See Instructions on Reverse Side

1. Name of Injured Employee (Last, first, middle)	2. OWCP File Number, if known
JACKSON, Jim A.	A13-0112221
3. Home Mailing Address (include zip code)	**4. Social Security Number**
4444 Hickory Street, Tucson AZ 85714	444-55-6666

5. Date and Hour of Injury (Mo., day, year)
12-29-95 — 10:15 ☒ AM ☐ PM

6. Period Compensation Is Claimed As a Result of Pay Loss (Mo., day, year) If pay loss was intermittent attach separate sheet showing dates and hours of pay loss.
From: 02-27-96 Through: 03-12-96

7. Have you received any leave pay during the period shown in item 6?
☐ Yes ☒ No Show Inclusive Dates. From: Through:
If leave use was intermittent, attach separate sheet showing dates and hours used.

8. Do you wish to repurchase leave?
☐ Yes ☒ No

9. Complete this item if you worked anywhere during the period shown in item 6. Attach a separate sheet if needed.

a. Salaried Employment,

Dates & Hours Worked	Pay Rate (Per hour, day or week)	Total Amount Earned	Type Work Performed	Name & Address of Employer
Did Not Work				

b. Commission and Self-Employment. Show all activities, whether or not income resulted from your efforts.

Dates & Hours Worked	Name and Address of Business	Self-Employed ☐ Commission ☐	Type of Activity Performed	Income Derived (Attach Explanation if Needed)
None				

10. If you were only partially disabled and did not work, state reason for not working.

Totally Disabled

11. If, since filing your initial claim for compensation, you have applied for or received VA Benefits based on Military Service for the United States, give the following:

Claim No.	Date of Disability and Monthly Payment	Name and Address of Office Where Claim Is Filed
N/A		

12. If, since filing your initial claim for compensation, you have applied for or received an annuity under the Civil Service Retirement Act or other Federal retirement or disability law, give the following:

Claim No.	Amount of Monthly Payment	Name and Address of Office Where Claim Is Filed
N/A		

13. SIGNATURE OF EMPLOYEE OR PERSON ACTING ON EMPLOYEE'S BEHALF.

Jim A. Jackson

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

14. Date (Mo., day, year)
3-3-96

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Statement of Official Superior

15. If employee has returned to work, show date and hour (Mo., day, year)

Not Yet ☐ AM ☐ PM

16. Show employee's work week on return to duty, if other than Monday thru Friday

S	M	T	W	T	F	S

17. Has employee received any pay for work, leave, subsistence, quarters or other remuneration from your agency during the period shown in item 6 on the reverse side?

☐ Yes ☒ No

18. If answer to item 17 is Yes, show:

Amount: $

Type of Payment:

Period: From: _____ Through: _____

19. If there has been any change in employee's health benefit enrollment and/or optional insurance since previous claim for compensation was submitted, please explain. (i.e. change of plan or option; if additional deductions have been made by the agency, show amount and period.)

N/A

20. Remarks

21. A supervisor who knowingly certifies to any false statement misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

22. Signature of Official Superior	23. Title	24. Date (mo., day, year)
Jerry C. Jones	Store Manager	3-3-96

Instructions for Injured Employee

a. Items 1 through 14 on the reverse side should be completed by the injured employee or by someone acting on the employee's behalf. The form should then be given to the official superior.

b. The injured employee should file Form CA-8 each two weeks during the period of disability unless otherwise notified by OWCP. Forms may be obtained from OWCP or the employing agency.

c. Employees are advised that fraudulent claims are punishable by a fine of not more than $10,000, or imprisonment for not more than five years, or both.

d. The employee is responsible for submitting, or arranging for the submission of medical evidence in support of this claim. The CA-20a is attached to form CA-8 for this purpose. The employee should complete items 1 - 6 on form CA-20a. The attending physician should complete items 7 through 23. The address of the appropriate OWCP office should be entered in item 3 on the reverse of the CA-20a.

Instructions for Official Superior

a. The official superior must complete items 15 through 24 and forward the form, and any accompanying medical report, to the appropriate OWCP office, within 5 working days of receipt from the employee.

If additonal space is required for any reply, a separate sheet of paper may be used, numbering the answers to correspond with items on the form.

Note: Failure to submit this form properly completed with supporting medical evidence will delay payment of compensation.

Figure 810-20. Form CA-8 Continued.

Attending Physician's Supplemental Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

For Instructions See Reverse Side

OMB No. 1215-0103
Expires: 09-30-91

1. Name of injured employee (Last, first, middle)
JACKSON, Jim A.

2. OWCP File Number, if known
A13-0112221

3. Home mailing address (Include Zip code)
4444 Hickory St., Tucson, AZ 85714

4. Social Security Number
444-55-3333

5. Date and hour of injury (Mo., day, year)
12-29-95
10:15 [XX] AM [ ] PM

6. Period compensation is claimed as a result of pay loss (Mo., day, year)
From: 2-27-96 Through: 3-12-96

7. Date of most recent examination (Mo., day,year)
12-29-95

8. Is employee's present condition due to the injury for which compensation is claimed?
[X] Yes [ ] No

9. Is employee totally disabled for usual work?
[X] Yes [ ] No

10. Describe nature of present impairment

11. State diagnosis

11a. ICD-9 Code

12. What treatment is employee receiving and how often is it given?

13. What permanent effects, if any, are anticipated?

14 Describe any concurrent disability employee has which is not related to this injury

15. Will disability for regular work continue for 90 days or longer?
[ ] Yes [X] No
If no, approximately what date will employee be able to return to work? (Mo., day, year)

16. If employee is able to resume regular work, has he or she been advised? [ ] Yes [ ] No N/A
If Yes, show date employee was informed (Mo., day, year)

17. If employee is only partially disabled, show date he or she was able to perform some work and describe specific work restrictions. (i.e. limitations in stooping, bending, lifting, etc.)

18. If employee has been referred to another physician for consultation or treatment, give physician's name & address.

19. Recommendations and Prognosis

20. Address (Include Zip code)

21. If you specialize, indicate specialty

22. Signature of Physician. I certify that the statements on the reverse apply to this report and are made a part hereof.

23. Date of Report (Mo., day, year)

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of Information Management, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.

Form CA-20a
Rev. June 1990

Figure 810-20 Continued. Form CA-8 with CA-20a

INSTRUCTIONS FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

CERTIFICATION: BY SIGNING BLOCK 22 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-20a ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

IMPORTANT:

A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A MEDICAL REPORT ON FORM CA-16, CA20 OR A NARRATIVE REPORT TO THE OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20a.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM,. HCFA-1500/0WCP 1500a.

1. Complete the entries 7-23 on this report (and items 1-6 if not previously completed), and
2. Forward the report directly by mail to the OWCP office indicated below.
3.

OFFICE OF WORKERS' COMPENSATION PROGRAMS

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

*U.S. GPO:1990-262-252/15425

Figure 810-20 Continued

Instructions for Completing Form CA-8, Claim for Continuation of Compensation on Account of Disability With CA-20a Attending Physician's Report

Statement of Injured Employee. The employee or someone acting in his/her behalf completes Items 1 through 14. Employee:
Item 1. Enter your last, first, and middle names (enter "NMN" if no middle name).
Item 2. Enter your OWCP number, if known.
Item 3. Enter your complete home mailing address, including ZIP code.
Item 4. Self-explanatory.
Item 5. Enter date and hour of injury or illness as shown on Form CA-1 or CA-2.
Item 6. Enter beginning and ending dates. The beginning date should be the first day following the ending date of the previous claim.
Item 7. Check appropriate box. If yes, indicate amount received with the specific dates covered by leave.
Item 8. Check appropriate box.
Item 9. Complete only if any work was performed during the period claimed in Item 6. Include self-employment, military reserve duty, or other jobs held. If no work was performed, enter "NA."
Items 10 and 11. Self-explanatory.
Item 12. If you have applied for or received an annuity from OPM or other federal retirement or disability law, furnish the information requested.
Item 13. Enter your signature or signature of person acting on your (employee's) behalf.
Item 14. Date signed.

Statement of Official Superior. Superior:
Item 15. Enter month, day, year, and time employee returned to work. If employee has not returned to work at the time the Form CA-8 is submitted, enter "HAS NOT RETURNED."
Item 16. If has not returned, enter "NA." If returned, circle the scheduled workdays of employee.
Item 17. Check appropriate box.
Item 18. Self-explanatory.
Item 19. Indicate any change in employee's health coverage.
Items 20 and 21. Self-explanatory.
Item 22. Your signature.
Items 23 and 24. Self-explanatory.

Special Note: CA-20a should be attached to CA-8 to support claim being made.

Figure 810-20. Instructions for Completing CA-8.

USE INSTALLATION LETTERHEAD

FROM: AAAA-BB Date

SUBJECT: Claim for Compensation, Form CA-8

TO: Employee Name
Street Address
City, State, Zip Code

Dear Mr. Jones:

The attached Form CA-8, Claim for Continuing Compensation on Account of Disability, is forwarded for your completion of Items 6 through 14 as required in the instructions on the reverse side of the form.

This claim for compensation covers the period _____ through _____ (14 days). Return the completed form to this office no later than _____ (date) for completion of Items 15 through 24 and forwarding to the Office of Workers' Compensation Programs. A self-addressed envelope is enclosed for your convenience.

Form CA-20a, Attending Physician's Supplemental Report (is/is not) enclosed. If attached, please ask your attending physician to complete the form. You should provide the CA-20a to this office with the completed Form CA-8. Failure to return these forms by the required date may delay your compensation payment.

Your are reminded that fraudulent claims are punishable by a fine of not more than $10,000, or imprisonment for not more than five years, or both. If you receive any compensation checks after you have returned to work, return them to OWCP immediately.

If you have any questions, please call me at 111-222-3333.

Sincerely,

2 Encl
1. CA-8 w/envelope
2. CA-20a w/envelope

MELVIN A. BROWN
Injury Compensation Program
Administrator

Figure 810-21. Sample Letter to Employee Forwarding CA-8.